STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES
DIVISION OF CHILD MENTAL HEALTH SERVICES
APPLICATION FOR INITIAL APPOINTMENT TO THE PRACTITIONER PANEL

A. IDENTIFYING INFORMATION:

Name: _____

Date of Birth: _____

Check Appropriate Discipline:

- ☐ Psychologist
- ☐ Licensed Clinical Social Worker
- ☐ Psych/MH Nurse Practitioner, with national certification in child/adolescent psych mental health
- ☐ Licensed Professional Counselor of Mental Health
- ☐ Physician with a specialty in psychiatry
- ☐ Licensed Marriage and Family Therapist
- ☐ Psych/MH Clinical Nurse Specialist, with national certification in child/adolescent psych mental health
- ☐ Licensed Chemical Dependency Professional

B. EDUCATION INFORMATION:

Name and Address of Graduate College or University:

_____

_____

_____

Year Graduated _____

C. ADDITIONAL INFORMATION IF YOU ARE APPLYING AS A PSYCHIATRIST:

Drug Enforcement Administration Number: _____

Date of Expiration: _____

If you are a foreign Medical School Graduate, what is your ECFMG Number?

_____

D. PRACTITIONER CHECKLIST*

1. Has your professional liability insurance ever denied, canceled, or non-renewed? ☐ Yes ☐ No
2. Have you ever had your medical or professional license or registration revoked, suspended, or limited? ☐ Yes ☐ No
3. Have you ever voluntarily relinquished your professional license or registration when there was a challenge or pending challenge to the professional license? ☐ Yes ☐ No
4. Is there a pending challenge to your professional license or registration? ☐ Yes ☐ No
5. Has your professional or clinical staff membership ever been voluntarily or involuntarily suspended or terminated? ☐ Yes ☐ No
6. Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension, or revocation of such privilege? ☐ Yes ☐ No
7. Has Medicare, Medicaid, or any other federal, state or local authority brought charges against you for alleged inappropriate rates, billing, or quality of care issues? ☐ Yes ☐ No
8. Have you ever been named as a defendant in any criminal proceeding? ☐ Yes ☐ No
9. Have you ever been convicted of any crime involving the abuse of minors? ☐ Yes ☐ No
10. Have you ever been subject of disciplinary actions by any professional association or organization, e.g., licensing board? ☐ Yes ☐ No
11. Has your facility membership in any medical or other professional school ever not been renewed or subject to disciplinary action? ☐ Yes ☐ No
12. Are there any current health problems that make you unable to carry out any essential professional duties as defined by the requested appointment and privileges, and your job description in the agency under the contract being sought? ☐ Yes ☐ No
13. Are you aware of any pending malpractice claims? ☐ Yes ☐ No
14. Have you ever had any malpractice claims settled? ☐ Yes ☐ No
15. Have you ever been debarred from contracting with the State of Delaware, any other State or the government of the United States? ☐ Yes ☐ No

PSYCHIATRISTS ONLY

16. Have you ever had your permit to prescribe drugs revoked or suspended? ☐ Yes ☐ No
17. Has your specialty board status ever been suspended, diminished, revoked or not renewed? ☐ Yes ☐ No

***NOTE:** For each item checked **yes**, attach a detailed description of the event, including copies of relevant information. See credentialing checklist, Section III., page 5.

E. RECOMMENDATION FORM

Check the applicant's appropriate discipline:

- □ Psychologist
- □ Licensed Clinical Social Worker
- □ Psych/MH Nurse Practitioner
- □ Licensed Professional Counselor of Mental Health
- □ Physician with a specialty in psychiatry
- □ Licensed Marriage and Family Therapist
- □ Psych/MH Clinical Nurse Specialist
- □ Licensed Chemical Dependency Professional

I, _____ (Name of Reviewer) attest to the professional competence of _____ (Name of the Applicant) to provide individual, family and group treatment within the scope of their licensure.

Check all categories below that apply to your professional experience with this individual.

1. Written personnel evaluation demonstrating satisfactory performance of essential job tasks through observation of daily work, client satisfaction information, findings from quality improvement activities, etc. □ Yes □ No
2. Internal QI/peer review of a representative sample of individual's records which demonstrates use of professional values and ethics in providing services. □ Yes □ No
3. Participation with individual in group supervision /team meetings with direct observation of professional interaction within a clinical context. □ Yes □ No
4. Participation on a regular basis in multi-system case conferences, discharge and aftercare planning and other clinical activities. □ Yes □ No
5. Participation in agency/community committees with direct observation of individual demonstrating teamwork, providing meaningful input, and timely completion of tasks. □ Yes □ No
6. Professional consultation with individual about clinical issues. □ Yes □ No
7. Other (describe)_____

To be completed about the reviewer:

How many years have you known the applicant in a professional capacity? _____

Licensing State and License Number: _____

I verify that my professional license is in good standing with the appropriate regulatory board. If applicable, I also verify that I am in good standing as a member of the DCMHS network practitioner panel.

Reviewer's Signature: _____ Date: _____

Please submit directly to the address below with a copy to the applicant:
Division of Child Mental Health Services
Credentialing Committee
1825 Faulkland Road
Wilmington, DE 19805

F. PRACTITIONER STATEMENT

I grant the Division of Child Mental Health Services permission and consent to obtain and verify information contained in this application and consent for any person, organization, or other entity to release to the Division of Child Mental Health Services all information that may be reasonably relevant to an evaluation of my professional competence to or ability to render clinical services in a professional and cost-effective manner.

I certify that the information in this application is true, correct and complete. I fully understand that if I have misrepresented any information provided in this application, the Division of Child Mental Health Services is entitled to terminate my membership on the practitioner panel. I will not provide services to DCMHS clients until the agency receives notification of appropriate appointment by the DCMHS Credentialing Committee.

The Agency CEO (or designee) has reviewed the application and acknowledges the appointment applied for is consistent with the agency's mission and the types of care I provide in the agency. If in the event there are any changes in the status of the items noted on the Practitioner Checklist which would impair my capacity to provide care within the 3 year appointment period, (i.e. license suspension) the Agency CEO (or designee) will notify the DCMHS Credentialing Committee within thirty (30) days of becoming aware of the changes.

Individual Practitioner Signature: _____

Date _____/_____/_____

Agency CEO Signature (or designee):_____

Date _____/_____/_____

G. CREDENTIALING DOCUMENTS CHECKLIST

Section I. Items under this section are required by all applicants unless otherwise indicated in the general directions. Check and date next to each item what you are submitting.

APPLICANT			DCMHS	
Submitted	**Date**		**Received**	**Date**
_____	_____	Application Form	_____	_____
_____	_____	Copy of Delaware Professional License	_____	_____
_____	_____	Copy of Resume	_____	_____
_____	_____	Evidence of Malpractice Insurance Coverage	_____	_____

Section II. In addition to the above psychiatrists must also submit these items:

_____	_____	Copy of Delaware Uniform Controlled Substance Registration Certificate	_____	_____
_____	_____	Copy of Federal Controlled Substance Registration Certificate	_____	_____

Section III. This section is required if you answered **yes** on any items on the Practitioner Checklist:

_____	_____	Detailed Description/Supporting Documentation	_____	_____

Section IV. Primary Verification of School Transcripts and Professional Recommendations

Requested from _____ (Name of graduate school) on _____ (Date)	_____	_____
Requested from _____ (Name of reviewer) on _____ (Date)	_____	_____
Requested from _____ (Name of reviewer) on _____ (Date)	_____	_____

Initial Application, Credentialing Checklist, and support documents must be mailed or delivered to:

Division of Child Mental Health Services
Credentialing Committee
1825 Faulkland Road
Wilmington, DE 19805